

REMARKS

The Office Action of August 15, 2003 and the references cited therein have now been carefully studied. Reconsideration and allowance of this application are respectfully urged.

As described in the previous amendments filed in this application, the present invention is directed to a system and method for automatically reviewing medical treatment claims provided by a plurality of medical practitioners to a plurality of insurance entities. The main purpose of this system and method is to determine whether medical practitioners such as doctors, physical therapists, occupational therapists and the like are submitting fraudulent claims. For example, in the past, medical insurance claims were directly transmitted to an insurance company on a particular form including the name of the patient, the time period during which treatment was provided to the patient as well as the treatment itself. Since there was generally no communication between insurance companies, it was quite conceivable that that same medical practitioner could claim the treatment of a second patient during the same period of time that a claim was made to the first patient as long as that second patient's claim was made to a second insurance company.

Quite recently, systems have been developed utilizing a clearing house through which medical practitioners would send claims relating to a plurality of insurance entities. However, while these clearing houses would be useful in streamlining the process in which the medical practitioners would be paid, the focus has not always been to reduce fraudulent claims. The present invention addresses this situation by providing software allowing the clearing house to determine whether the number of hours a particular medical practitioner has billed one or more of the insurance entities would exceed the total amount of hours possible, such as billing for ten hours of time during an eight hour billing period. Additionally, the software provided by the present invention would have the ability to determine whether a single medical practitioner has submitted more than one medical

treatment claim for a single block of treatment time for different patients.

The Examiner has rejected all of the claims previously included in the present invention under 35 U.S.C. §103(a) as being unpatentable over United States patents to Peterson et al, Little et al, Pendleton, Jr. as well as a published reference entitled "Clamping Down on Code Creep" authored by Kenneth Kienle. These rejections are respectfully traversed.

All of the above-cited United States patents were utilized by the Examiner in previous rejections and have been discussed in the undersigned's previously filed Amendments. Previously submitted Amendment C stressed the fact that independent claims 1 and 13 were directed to a system and method for reviewing medical treatment claims. Both of these claims specifically recited a system or method in which a single practitioner submitted more than one disparate medical treatment claim for a single block of treatment time on a single day. It was stressed to the Examiner that the feature of providing software for determining whether disparate medical treatment claims for a single block of treatment time on a single day were not disclosed in the prior art. Claims 22 and 23 were dependent from claim 1 and claim 13 respectively and recited the fact that the one disparate medical claim for a single period of time on a single day claims treatment to different patients. Based upon this Amendment, the Examiner cited the Kienle article in the Office Action mailed on August 15, 2003. This article which does appear to address the situation as recited in claims 1 and 13 in which a practitioner billed an insurance company for procedures which could not have been accomplished for a single patient during a single block of treatment time. However, the article to Kienle does not address the situation in which more than one patient would be billed for treatments provided by a medical practitioner during a single block of time. Consequently, applicant has canceled claims 22 and 23 and has inserted the subject matter therefrom into claims 1 and 13 respectively.

The Examiner in the Office Action mailed on March 26, 2003 rejected claims 22 and 23 while admitting that the cited

prior art does not explicitly disclose "wherein the single practitioner has submitted a medical treatment claim for more than one patient for a single period of time on a single day." However, in making this rejection, the Examiner took official notice that it was known in the claims fraud detection arts to flag multiple claims submitted for more than one patient at a single period of time on a single day from a provider. The undersigned in Amendment C did traverse this rejection by the Examiner. However, in the Office Action mailed on August 15, 2003, the Examiner maintained this rejection without submitting any prior art showing it to be the case.

On numerous occasions, the issue of official notice or judicial notice have been addressed by the courts. For example, in re Ahlert and Kruger 165 U.S.P.Q. 418, 420 (CCPA 1970), specifically stated that "as to the propriety of the boards taking such notice at all, this court has already determined that the Patent Office appellate tribunals, where it is found necessary, may take notice of facts beyond the record, while not generally notorious, are capable of such instant and unquestionable demonstration as to defy dispute." Furthermore, as discussed in in re Zurko 57 U.S.P.Q. 2(d) 1693, 1695 (Fed.Cir. 2001) when responding to the Board's decision including a rejection in which the Board used official notice to reject the claim, the Court of Appeals stated,

"We cannot accept these findings by the Board. This assessment of basic knowledge and common sense was not based on any evidence in the record, and therefore, lacks substantial evidence support. As an administrative tribunal, the Board clearly has expertise in the subject matter over which it exercises jurisdiction. This expertise may provide sufficient support for conclusions as to peripheral issues. With respect to core factual findings in the determination of patentability, however, the Board cannot simply reach conclusions based upon its own understanding or experience-or on its assessment of what would be basic knowledge or common sense.

Rather, the Board must point to some concrete evidence in the record to support of these findings. To hold otherwise would render the process of appellate review for substantial evidence on the record a meaningless exercise."

While it is admitted that it is an objective of many systems to which medical claims are submitted to reduce fraud, it is not admitted that the manner in which this is accomplished by Applicant's method and system as previously recited in claims 22 and 23 and now included in amended claims 1 and 13, are not common knowledge. Since they are not common knowledge, and the undersigned in Amendment C traversed the Examiner's official notice rejection based upon common knowledge, therefore as indicated in Section 2144.03 (C) of the MPEP, if the Examiner were to maintain the rejection, additional art must have been provided. This was not done in the Office Action of August 15, 2003, in which the Examiner merely repeated this rejection.

There is no question that if a medical practitioner would submit two separate claims to two different insurance companies in which the medical practitioner claimed to provide treatment on a single block of time to two different patients, this type of medical fraud would not be detected. This is true because the two insurance entities would not have the ability to check on the existence of conflicting claims from other insurance companies. These types of fraudulent claims could in theory be detected if a clearing house was established for processing medical claims for more than one insurance entity. However, even the existence of such a clearing house would not necessarily render the system as recited in amended claims 1 and 13 obvious. It is respectfully submitted that the Examiner is using hindsight and Applicant's own disclosure to make the determination that such a system and method of combating medical fraud would be obvious. The medical clearing house system described in the Peterson et al patent must be modified to include software capable of detecting such fraud. This type of software would allow a first claim submitted by a medical practitioner for a

single block of time to be paid. However, if that same medical practitioner submitted a second claim for that same period of time for a different patient, the software utilized by the Peterson et al clearing house would not have detected the medical fraud. Rather, the software utilized by the system and method of the present invention must have the ability to check each and every medical practitioner and each and every block of treatment time before each and every claim is completely processed. Since it would not be common knowledge to operate a system in this manner, it is respectfully urged that claims 1 and 13 and all of the claims depending therefrom are not rendered obvious by the art cited by the Examiner. It is believed that these claims should be allowed. However, if the Examiner does not allow these claims, additional prior art must be provided by the Examiner showing the features previously recited in claims 22 and 23 which have now been incorporated into independent claims 1 and 13.

Additionally, the Examiner has rejected claims 4, 5 as well as 17 and 18 under 35 U.S.C. §103(a) as applied by the Peterson, Little, Kienle and Pendleton, Jr. references. These rejections are respectfully traversed.

Claims 17 and 18 are directed to a method and system wherein software operated by the clearing house determines the appropriateness of claims based upon the total number of hours submitted by one of the practitioners for a particular duration of time, such as one work day. In making this rejection, the Examiner has indicated that the patent to Pendleton, Jr. discloses software for determining the appropriateness of claims based upon the total number of claim hours submitted by one of the practitioners for a particular duration of time. However, it is believed that the Pendleton, Jr. reference does not process a claim based upon the appropriateness of the total number of claim hours submitted for a particular duration of time as one work day. The system illustrated in Figure 12 and described in column 9, lines 35-64 of Pendleton, Jr. is directed to situation in which provider records are reviewed (See block 158) for various factors. However, these factors do not specifically

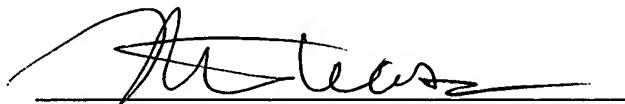
relate to the claim hours submitted by the practitioners. For example,

"With reference to FIG. 12, the initial step in the system determination process involves reading provider records (block 158) from NN Database file 72. Each record is then analyzed by an expert system inference engine (block 160) in accordance with a plurality of expert system rules 152. An illustrative example of a situation addressed by expert system rules 162 is the provider who is "new" to the Medicare Program (i.e.), has just recently begun billing Medicare for services), and who submits claims for numerous and expensive services. In this case, the expert system may identify the provider as potentially fraudulent." (See column 9, lines 35-45).

Therefore, it is believed that the subject matter recited in claims 4, 5, 17 and 18 are not rendered obvious by the references cited by the Examiner. Consequently, reconsideration and allowance of these claims are earnestly solicited.

It is believed that all of the claims now present in this application do recite patentable subject matter. Therefore, reconsideration and allowance of this application are earnestly solicited.

Respectfully submitted,



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November 17, 2003

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Attorney's Docket: A-7709.AMD/eb